

on the measurement and reporting of clinical outcomes. **CONCLUSIONS:** PAS were pioneered by the beta interferon outcomes-based scheme for multiple sclerosis, 2002. Since then, published UK-based schemes favour price or volume-based schemes, a trend illustrated by two of the three newest schemes published in 2010. The simplicity of financial-based agreements, combined with poor health care system uptake of outcomes-based schemes and the demand for value-based pricing, suggests that this trend is set to continue.

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PATIENT ACCESS SCHEMES (PAS) IN THE UK COMING OF AGE: WHAT IMPACT WILL THEY HAVE ON OTHER EU COUNTRIES LIKE ITALY?

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OBJECTIVES: Although patient access schemes (PAS) have historically been implemented for high-cost oncology drugs, recent schemes for chronic diseases like rheumatoid arthritis (RA) have been seen in the UK. This study tries to understand how the shift in PAS from being accepted by payers only for short-term oncology drugs to those for chronic diseases like RA in the UK will influence the situation in Italy, where PAS are known to be widespread. **METHODS:** This study used qualitative telephone interviews to analyze trends in the UK (n = 7) and Italy (n = 7). Interviews were conducted in tertiary hospitals as well as local, regional and national level reimbursement authorities involving financial and clinical stakeholders, and key individuals in the implementation of the scheme. Importance of a number of variables affecting new PAS was ranked. **RESULTS:** Budget-holders in both markets were seen to be sceptical about the impact on long-term budgets due to the move towards PAS for chronic conditions. Of the 14 stakeholders interviewed, 9 said that such schemes in chronic conditions might help companies access markets with lesser clinical evidence on the basis of the class-effect of the drugs and the risk-sharing nature of the schemes. Monitoring of the outcomes on implementation was thought to be crucial. **CONCLUSIONS:** In Italy, increase in PAS for chronic diseases will help drug companies bring drugs to the market earlier. On the other hand, the payers will see this as an increased burden on their budgets as it will mean funding longer term treatment. Also, due to recent issues with monitoring of outcomes in PAS in the UK, their future needs re-consideration. This move of PAS towards chronic conditions is expected to increase the impact that post-marketing monitoring will have on market access for expensive 'me-too' drugs in the EU.

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ADOPTING A FINANCIAL RISK-SHARING SCHEME FOR NEW TECHNOLOGIES ADDED TO THE NATIONAL LIST OF HEALTH SERVICES IN ISRAEL: STAKEHOLDERS' STATED INCENTIVES AND DISINCENTIVES

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OBJECTIVES: To explore major stakeholders' incentives and disincentives to adopt a financial risk-sharing mechanism regarding budget-impact estimates of adopting new technologies in the Israeli National List of Health Services (NLHS). According to the proposed scheme, HMOs will be partially compensated by the pharmaceutical and medical device industry if actual use of a technology is substantially higher than what was projected and allocated. On the other hand, HMOs will partially refund the government for budgets allocated to specific technologies that were not fully used. These unused budgets will be used for adopting other technologies in subsequent years. **METHODS:** Using a semi-structured protocol, we interviewed major stakeholders involved in the process of updating the NLHS (N = 31). Interviewees included government officials, senior managers in the country's four HMOs, pharmaceutical industry executives, and health economists. We inquired into the interviewee's view towards our proposed risk-sharing mechanism, and their opinion on the other stakeholders' incentives to accept or object the proposed scheme. **RESULTS:** Our interviews revealed a wide range of incentives, disincentives, and barriers for adopting the risk-sharing mechanism. There was no consensus on what would be the different stakeholders' incentives and disincentives for adopting the proposed mechanism, even within the various stakeholders groups themselves. Most interviewees from the HMOs and the pharmaceutical industry supported the proposed risk-sharing agreement. Among government officials, the Ministry of Finance decision-makers tended to object to the proposed mechanism, while Ministry of Health executives usually supported the scheme, but believed that the pharmaceutical industry will not support this risk-sharing agreement. **CONCLUSIONS:** Since the success of implementing a risk-sharing mechanism depends mainly on its perception as a win-win situation for all stakeholders, we recommend that decision-makers consider the different incentives and disincentives exposed in our interviews, when implementing such a mechanism.

HEALTH CARE USE & POLICY STUDIES – Beyond Drug Interventions

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THE USE OF HEALTH PROMOTION INITIATIVES BY MUNICIPALITIES IN BELGIUM. A RETROSPECTIVE OBSERVATIONAL STUDY

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OBJECTIVES: Growing attention is currently given to preventive health care. Prevention can decline the appearance of several diseases and as a consequence lead to a

decrease of health care expenses. The aim of this study was to evaluate if municipalities in Belgium currently are using intervention strategies for optimizing the health behavior of citizens. Special attention was given to what extent certain high-risk groups are reached. **METHODS:** The design consisted of a retrospective observational design. The general services or—if existing—the sports services of 570 Belgian cities (308 in the Flanders and 262 in the Walloon region) were invited by e-mail to participate in the study. After the first mailing, another two mailings were performed. The data were collected using an online questionnaire with closed questions. PASW Statistics 18 was used for statistical analysis. **RESULTS:** The response rate in the Flemish region and Walloon region was respectively 57.47% and 16.41%. In Flanders, 94.9% of respondents reported that they organize health promotion initiatives, while in Wallonia this percentage was 65.1%. Most common organized initiatives in the Flanders region were sport (74.4%) and social welfare (46.4%) initiatives. In Wallonia most common initiatives were prevention of disease/vaccination (45.3%) and sport (44%). Both in Flanders and Wallonia, initiatives concerning mental health were little organized. In general, the initiatives aimed at certain high-risk groups such as persons with mental health problems, older and disabled persons were scarce. On the level of municipal policy lack of appropriate financing was reported as the most common barrier for not organizing preventive strategies. **CONCLUSIONS:** On the level of municipal policy reinforcement of the value of preventive strategies concerning health promotion with appropriate financing is required. When organizing preventive initiatives, special attention to reach certain high-risk groups will be needed.

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ATTITUDES OF HUNGARIAN POPULATION TOWARD CO-PAYMENTS

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OBJECTIVES: The issue of the introduction of co-payments is a great policy challenge in most of the Central-Eastern European countries. This is also the case in Hungary, where visit fee was introduced for health care services in 2007, and abolished one year later as a result of a referendum. The aim of our study is to identify different types of attitudes towards patient payments, and answer why visit fee was so unpopular among Hungarian population. **METHODS:** 8 focus-group discussions with health care consumers and physicians and 7 in-depth interviews with policy makers were conducted in Hungary during the summer 2009 on the attitude of patient payments in health care. **RESULTS:** Based on the transcripts and questionnaires filled in by all respondents during the focus group discussions and interviews three different groups of attitude were identified. The group of "Supporters" support the introduction of patient payments with the aim of controlling the unnecessary use of services. The group of "Undecided" concern patient payments as an opportunity to provide additional resource for health care system by paying for "extra-better-quality services". "Sceptics" strongly refuse the idea of patient payments mainly referring to ethical issues. Consumers mainly belong to the group of "Undecided", while one part of the physicians belongs to "Supporters", the other part to "Sceptics". Policy makers are all belong to the group of "Supporters". **CONCLUSIONS:** Before the implementation of patient payments, mapping of population's attitude is inevitable. In Hungary the failure of the introduction of visit fee can be explained by different expectations of health care consumers. They are not against to pay for health care services, but expecting better quality of provided services in return.

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TRENDS IN COST CONTAINMENT MEASURES

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OBJECTIVES: In the current economic climate health authorities are finding ways to control spending. A popular measure is the introduction of cost containment strategies for pharmaceuticals to lessen the burden of cost of drugs. The objective of this research was to analyze the importance of different cost containment measures that payers use in selected markets. The research extends to analyze the gaps between the policies on paper and the extent these are interpreted and executed in practice. **METHODS:** Interviews were conducted with payers at the national, regional and local level in selected European and non-European markets. **RESULTS:** All countries utilise different measures to control spending on pharmaceuticals. The measures that are used by markets include: internal therapeutic referencing, international price referencing, generic substitution, risk-sharing agreements, budget caps, profit caps, index pricing, price cuts, rebates and price volume agreements. The critical finding from the research was that although combinations of measures are included in the national and regional policies, in reality their interpretation and execution varies substantially. For example, Spain uses internal referencing and price referencing at the national level, regions apply price discounts and rebates. Similarly, in The Netherlands a preferred drug policy is introduced, which means that health insurers can now choose a preferred drug for reimbursement, which is usually the cheapest option of the reference basket. If the patient does not want this product, they have to pay the full price of the other product. Another European country which has become the recent focus is Germany; where price regulation will become dominant in the near future. There are uncertainties on achievable prices of drugs, one reason being there is lack of sophisticated systems in place that can monitor these measures. **CONCLUSIONS:** There are currently many developments in the area of cost containment of pharmaceuticals which will have a profound effect on the pharmaceutical industry.